

YESHIVA UNIVERSITY
MEAL PLAN MODIFICATION REQUEST
VERIFICATION FORM FOR MEDICAL PROVIDERS

Purpose: The student named below has indicated that s/he has a disorder and will require partial modification or full exemption from the meal plan at Yeshiva University.

The information you provide will be used to determine the nature and severity of the student's condition and the appropriateness of requested modification/exemption. Upon receipt, this form will be forwarded to our medical staff for review. They may contact you for any additional information if necessary. **Please take the time to complete this form in its entirety.** Thank you for your assistance.

Please note: This form must be filled out by a professional qualified to assess the student's medical condition for requesting a change to the meal plan requirement.

Student Name:

Medical Diagnosis(es):

Onset of Condition(s):

Current Status of Condition(s) (e.g. Active, Progressing, Controlled, In Remission):

How long is this condition(s) likely to persist (*be as specific as possible: e.g., lifetime, one academic year; one semester*):

What are the student's current food limitations? Please specify:

'Please provide a specific diet or list of foods can the student tolerate:

Please describe the current impact that this will have on the student's ability to participate in the meal plan:

Anticipated duration of need for exemption or modification:

Additional information:

PLEASE ATTACH ANY DIAGNOSTIC TEST RESULTS THAT SUPPORT THE DIAGNOSIS(ES) AND REQUESTS LISTED ABOVE.

Name of Medical Professional:

License #:

Please indicate State:

Address:

Telephone:

Email:

Signature (verifying that you are not related to the student by blood or marriage):

Date:

Please return this form to the student who will forward it to the Office of Disability Services.